DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO THE DEATH OF TW

Twenty-one year old male inmate of Mecklenburg Correctional Center who died of an apparent suicide

I. INTRODUCTION:

This report is a summary of the findings from an investigation conducted on behalf of the Department for Rights of Virginians with Disabilities (DRVD) into the suicide of TW, a twenty-one-year-old black male inmate who was an inmate of Mecklenburg Correctional Center in Boydton, Virginia. TW hung himself by a sheet from the bars of his cell door, at approximately 2:00 a.m. on the morning on August 21, 1997.

The Department for Rights of Virginians with Disabilities authorized this investigation of an alleged incident of abuse and/or neglect of an individual with mental illness pursuant to the Developmental Disabilities Assistance and Bill of Rights Act, the Protection and Advocacy for Mentally Ill Individuals Act of 1986, and the implementing regulations.

TW had been incarcerated at Mecklenburg since February 14, 1997, when he was transferred from Greensville Correctional Center. He was serving a 53-year sentence for murder, a sentence imposed on February 23, 1995 when TW was 19 years of age. He had a history of mental health problems and also suicide attempts. TW had been placed in segregated status when he was transferred to Mecklenburg, and on August 5, 1997 was moved to an isolation unit. This move was made because he had begun to eat feces and smear feces around his segregation cell. During the months prior to his move to isolation, TW had repeatedly requested a transfer from Mecklenburg, preferably to a mental health unit. TW hung himself on August 21, a little more than two weeks after he was placed in isolation.

This investigation included the following:

1. Review of TW's records from the Department of Corrections (DOC) and pertinent records from the Norfolk Circuit Court.

2. Review of pertinent law, regulations, and inmates rights cases.
3. Review of several mental health policies and procedures furnished by the Department of Corrections.
4. Several interviews with Fred Greene, current Mecklenburg warden, and Dr. Robin Hulbert, mental health director for the DOC.
5. Site visits to Mecklenburg, including visits to the last two cells where TW was confined.
6. Numerous interviews with Mecklenburg personnel, including the prison psychologist, TW's unit counselors, and corrections officers who had contact with TW.
7. Interviews with counselor who had contact with TW at Greensville Correctional Center.
8. Interviews with TW's criminal attorney.
9. Review of material concerning jail and prison suicide furnished by several prisoners rights organizations.
10. Interview with Lindsay Hayes, Assistant Director of the National Center on Institutions and Alternatives (NCIA).

The investigator requested the following materials for review, but the DOC denied access:

1. The report on the internal investigation of TW's suicide.
2. The Medical Examiner's report, the autopsy report, and photos of the suicide scene.
3. Copies of relevant DOC policies concerning segregation assignment and monitoring of inmates so assigned, inmate behavior management, and use of restraints for both clinical and security reasons.
4. Material concerning the Basic Skills in Mental Health Issues course, including the policy on who must take the course and when.

II. BACKGROUND:

A. TW's Criminal, Social and Mental Health History

TW was a 21 year-old black male from Norfolk, Virginia. His education was limited to the ninth grade level. He had a lengthy history of juvenile offenses beginning in 1987. These included trespass, disorderly conduct, breaking and entering, petty larceny, assault, possession of cocaine, and destruction of property. TW was committed by the court to the Norfolk juvenile detention facility and other residential settings. TW reported multiple forms of substance abuse, including smoking marijuana laced with embalming fluid, inhaling "white out" and "Zippo" lighter fluid, and cocaine and heroin use.

Information in the records concerning TW's social and family history is patchy and inconsistent. He was raised primarily by a great-grandmother because, as he informed one mental health professional who examined him, no one else wanted him. He remained in contact with his great grandmother until his death. His mother and father, along with at least one of his brothers, apparently had a history of incarceration. His attendance in school was apparently erratic and he ran the streets in Norfolk with his friends when he was not in detention or a group home. While in detention, his behavior was destructive and disruptive. He exhibited a very low tolerance for frustration and poor impulse control.

TW had a long history of mental health problems. In 1991, when he was fourteen, he was ordered by the court to attend mental health counseling.

He apparently received counseling of various sorts when he was in detention facilities as a juvenile. In the months leading to the crime for which he was ultimately incarcerated at Mecklenburg, TW underwent a psychological evaluation while detained in the Norfolk Jail on a charge of destroying property at the Norfolk Detention Home. In that evaluation, a licensed psychologist from Riverpoint Psychological Associates described him as "an extremely angry and depressed young man," and give him an Axis I diagnosis of severe early onset dystymia [depression], solitary aggressive conduct disorder, and identity disorder. The Axis II diagnoses were borderline deficient intellectual functioning and a developing anti-social personality. The psychologist recommended a psychiatric evaluation to determine whether TW would benefit from psychotropic medication.

After the recommendation, Dr. M of Riverpoint Psychiatric Associates conducted a psychiatric evaluation of TW and concluded that he was sufficiently depressed to receive medication for that problem. He noted that TW had suicidal thoughts. He recommended that TW be committed to Central State Hospital where he could have access to a "complete inpatient psychiatric program." TW was not so committed, and shortly after the evaluation committed the crime for which he was ultimately incarcerated at Mecklenburg.

While awaiting trial and before sentencing, TW was incarcerated at the Norfolk Jail. During this time, he was admitted to Central State Hospital on three occasions due to suicide attempts, suicidal gestures, and depression. One suicidal gesture consisted of trying to hang himself. On these occasions, he was found to suffer from a depressive disorder, dystymia, conduct disorder, solitary aggressive type, and attention deficit hyperactivity disorder. He was also found to suffer from a psychosis, based in part on reports of

hallucinations. Some of the doctors who evaluated him believed that TW fabricated these reports in order to remain in the hospital. At the time of his last discharge from Central State, the doctors concluded that TW had exaggerated his symptoms. However, they diagnosed him with "Psychotic Disorder NOS" on Axis I, and the impairments listed above. Also, a neuropsychological evaluation indicated that TW had "clear organic, neurological impairment at the central and peripheral levels." At the time of his last discharge from Central State, in March of 1995, Mellaril was prescribed.

In February 1994, TW was evaluated for competency to stand trial. Dr. E, the psychologist who evaluated him, reported that TW had "extreme difficulties understanding what he is told," and recommended that TW receive a neuropsychological examination. This examination was performed by Dr. P of Neuropsychological Services of Virginia, Inc.

Dr. P's evaluation indicated significant neuropsychological abnormality, and Dr. P made a diagnosis of organic brain syndrome. The tests performed by Dr. P indicated moderate to severe dysfunction over a broad range of neuro-psychological function, including higher-level thinking and problem solving, visual and auditory memory, and attention/concentration. Brief lapse-type behavior, during which TW appeared to lose track of what was going on around him, indicated the possibility of seizures. While Dr. P determined that TW was not retarded, he exhibited "significant functional intellectual difficulty" which was consistent with the diagnosis of organic brain syndrome. Risk factors and indicators for this syndrome included drug use, head injury sustained in fights, and acting out and self-destructive behavior. Dr. P concluded that TW was functioning at "a primitive level," with a mental age ranging from eight to twelve years.

The pre-sentencing report on TW included a psychological report by Dr. Q. Dr. Q noted that TW suffered from an "impoverished upbringing, chronic depression, limited intellectual functioning, and deep psychopathological dysfunction." Dr. Q expressed pessimism, however, that TW would benefit from psychiatric hospitalization because prior experiences had produced limited and short-lived improvement. He stated that TW was in need of access to anti-depressant medication, and that the court might wish to place him in a facility which could take into consideration his medication schedule, need for mental illness management, and propensity for poor adjustment to structure.

B. History at DOC Institutions Prior to Transfer to Mecklenburg

Circumstances Surrounding the Transfer: In March 1995, after he was sentenced, TW was transferred to Powhatan Correctional Center, where he was placed initially in the mental health unit. He was also placed on fifteen-minute watches due to suicidal ideation. He had numerous behavioral infractions while at Powhatan, including threatening harm to both self and others. He was assigned an MH (Mental Health) 2 rating, which DOC policy indicates should apply to an inmate with a chronic condition with mild but stable symptoms who can function in the general population (see Section C, below). On May 19, 1995, TW was transferred to Greensville Correctional Center. He was still taking psychotropic medication at this time.

At Greensville, TW was placed in the mental health unit for a 21-day evaluation. He was diagnosed with major depression on Axis I and anti-social personality on Axis II. He was transferred to the general population, with follow-up to be provided by a qualified mental health professional (QMHP). He had numerous disciplinary offenses and spent considerable time in pre-hearing detention, segregation, and isolation (see Section D, below). He also exhibited self-mutilating and possibly suicidal behavior on numerous occasions. These incidents included cutting himself, swallowing wires and screws, and taking overdoses of medication. He had surgery to remove the wires and screws from his digestive tract.

In August 1996, TW applied for voluntary admission to Marion Correctional Treatment Center, which provides care for inmates with severe mental illness. His admission there was recommended by Dr. S, a psychiatrist with Correctional Medical Systems, a private contractor that provides mental health services to inmates. The records do not indicate the disposition of the request for a transfer to Marion, but it was apparently denied by officials at Marion.

After the denial of a transfer to Marion, TW began refusing medication. When this was brought to his attention, DG, a mental health professional at Greensville, responded that TW's problems were primarily "characterological" and "behavioral". TW continued to refuse medication, and the doctor gave permission to discontinue it.

In February 1997, following an incident of assaulting a guard and throwing an object at the warden, TW was transferred to Mecklenburg. He was on segregation status at the time of the transfer, and remained on that status at Mecklenburg. Mecklenburg at that time consisted of inmates on long-term segregation status as well as Death Row. During the investigation, Mecklenburg was described by several DOC officials as housing "the worst of

the worst" and "as low as you can go" in the DOC system. Unlike Greensville and Powhatan, Mecklenburg does not have a mental health unit.

Immediately before the transfer, DG, the mental health professional at Greensville, furnished a report to the warden at Greensville concerning TW's mental health status. In that report, DG stated that TW's primary problem was a personality disorder, rather than "any remarkable mental illness." DG did not mention TW's suicide attempts or self-mutilating behaviors. He concluded that TW was "malingering and manipulative" and was motivated to "act crazy" in order to obtain transfer to "easier time" in a mental health facility.

C. Brief Overview of DOC Mental Health System; Mental Health Service at Mecklenburg

Each inmate entering the DOC is seen by a Qualified Mental Health Professional (QMHP). The inmate is screened by the QMHP, and may undergo a more comprehensive assessment. Each inmate is assigned a mental health (MH) classification code from 0 to 4, with 0 indicating no mental health impairment and 4 indicating a severe impairment. A full description of the mental health classifications is attached.

Of particular interest to this case, MH-3 inmates are described as having "an ongoing mental disorder and may be chronically unstable. The inmate typically cannot function in the general population for extended periods of time and requires mental health treatment. The inmate may move into and out of mental health units as his/her condition deteriorates and then improves. Inmates coded as MH-3 must have a documented Axis I DSM-IV diagnosis." MH-2 inmates are those who have "a chronic psychological or psychiatric condition with symptoms which are usually mild but stable. The individual can typically function satisfactorily in a general population setting."

The DOC has adopted a policy concerning management of self-injurious and suicidal inmates. (DOP #780, attached.) The policy established two levels of suicide precautions, i.e. 15-minute watches and constant watch. Inmates are taken off suicide watch when a qualified mental health professional so recommends. Inmates on watch can be placed in stripped cells and modified stripped cells, and also in restraints as outlined in DOP #781 (see discussion below).

Several forms of mental health treatment are available to inmates at the DOC. The DOC maintains the Marion Correctional Treatment Center, to which inmates can be transferred on either a voluntary or involuntary basis for either

short or long-term treatment. Inmates can also receive treatment in sheltered care mental health units available at several facilities.

Long-term residential assignments are available at both Marion and also the Brunswick Correctional Center.

Unlike Powhatan and Greensville, discussed above, Mecklenburg does not have a mental health unit. At the time TW was incarcerated there, the institution had one psychologist, Dr. G, who was designated as Psychologist Senior. Dr. G was supposed to have another psychologist assisting her, but none was provided until recently, when Mecklenberg became a reception center for inmates entering the DOC system. Dr. G did not have a staff to assist her in working with inmates.

Dr. G did not have the time to schedule regular appointments with inmates such as TW. However, she reported that she saw any inmate who so requested as soon as she could, for approximately a one-half hour appointment. TW saw her on approximately nine occasions, seven of which were at his request; the remaining encounters were as the result of the self-injurious behavior described in Section IIIB below.

Corrections officers working in special housing units, such as those where TW was housed at Mecklenburg, are to receive a three-day class that includes basic skills in mental health issues. At the time TW was incarcerated, not all corrections officers had received this training. The investigator requested, but did not receive, further information about this course and information on which officers at Mecklenburg had taken the course. Several of the corrections officers interviewed described the mental health principle that a sudden change in behavior, e.g. a loud, outgoing inmate becoming withdrawn, raises concern and should be reported to a superior officer.

Corrections staff also includes individuals referred to as "counselors." These counselors do not provide treatment, but instead describe themselves as caseworkers or facilitators. The counselors function as a liaison between inmates and third parties, including prison administration and their families. They work with inmates to implement the institution's policies and procedures, assist inmates with various requests, and provide a "listening ear" to inmates. Counselors receive approximately one week of training in mental health counseling.

When an inmate becomes part of a counselor's caseload, the counselor is to review the file and then meet with the inmate. Counselors also make rounds to

speak with inmates on a regular basis. If an inmate has "mental health status," the counselor should be aware of it.

D. Inmate Housing Assignments, Restraint of Inmates

The investigator does not have detailed knowledge of the characteristics of various housing assignments and the reasons for them. As noted above, access was not provided to the policies that govern such assignments. However, sufficient information was provided by the warden and several corrections officers in order to state the following.

Inmates such as TW, who have difficulty functioning in the general population, may be given a segregation housing assignment. In general, such assignments are given to those inmates who "cannot or will not adjust" to the general population. In the general population, inmates have more access to education programs and jobs within the institution. They spend a considerable portion of the day outside their cells. They have access to group recreation, have contact visits and can purchase from the commissary, where they can purchase food items, toiletries, fans, and other small items.

In segregation, inmates spend most of each day in their cells. When TW was at Mecklenburg, recreation was limited to about five hours per week. At Mecklenburg, recreation for segregated inmates takes place not in groups, but in individual wire enclosures that resemble outdoor "runs" at a dog kennel. Before these enclosures were built, segregated inmates exercised in groups of twelve.

Segregated inmates have limited commissary access. They order items which are brought to them in their cells. Commissary privileges are sometimes taken away entirely for disciplinary infractions. Inmates in segregation can have a Walkman, but not the small screen TVs that are permitted for other inmates. They have access to books, as well as a few limited programs such as a literacy program. In segregation, inmates have only non-contact visits, during which they speak with the visitor on a telephone and are separated from the visitor by a glass barrier.

Inmates are generally placed in segregation for a minimum of ninety days. Some inmates at Mecklenburg have been in segregation for years. The investigator was informed that some inmates actually prefer segregation at least for short periods of time, because they have private cells rather than double-bunked cells.

Inmates can also be placed on isolation status as a disciplinary matter. In isolation, inmates are allowed even less property, no recreation, and commissary access only for paper, stamps and over-the-counter medication. They can remain in isolation only for 15 days. As will be described further below, TW's final housing placement was in a eight-cell block of isolation cells in a basement level of Building 1 at Mecklenburg.

Inmates in segregation and isolation are checked on an hourly basis, primarily for security reasons. Some of the checks throughout the day constitute official inmate "counts." Several of the counts during the daytime are "standing counts" during which the inmate must stand for the counting officer. At night, officers are supposed to see "flesh and movement" when they check the inmates. The officers use considerable discretion in carrying out this policy. Some officers vary the times they check so that the inmates do not know exactly when they will be observed, but this is not official policy.

Inmates are authorized to be placed in four-point restraints in their cells for both security and clinical reasons. The investigator was not given access to the DOC policy that governs restraint of inmates for security reasons, e.g. for assaultive behavior. Access was provided to the policy on restraint for clinical reasons, i.e. restraint of mentally disordered inmates who pose a substantial risk of harm to themselves and/or others. Inmates who are restrained for either reason are restrained to a bunk in the cell by their arms and legs, usually in a face-up position. They are partially or completely released from restraints at mealtimes, and for toilet use a minimum of four times each day. The restrained inmate's vital signs and circulation are kept regularly by nursing or medical staff. Inmates are generally not kept in restraints for longer than 48 hours.

It is DOC policy that inmates considered "at risk" are "identified, monitored, and managed for mental health services by a Qualified Mental Health Professional" while in a "special housing assignment," including segregation, isolation, and pre-hearing detention. This is to be done in order to reduce the risk of deterioration, self-harm, and of the inmate becoming a danger to self or others. (See DOP 779). An inmate is considered "at risk" if he meets at least one of several criteria, including receipt of inpatient mental health treatment within the last five years, having made a suicide attempt during the same period, or having an Axis I and/or Axis II disorder "which, in the judgment of the QMHP, may result in deterioration, self-harm, and/or being a danger to others."

Inmates who may be at risk are to be screened by a QMHP when they enter the facility. The QMHP must recommend against a special housing assignment if

she finds that such an assignment "may have a deleterious effect on an inmate's mental health." Alternatives include transfer to another facility, including to a mental health unit, and strategies for management in the general population. The QMHP can also recommend "special management instructions" for inmates in segregation. As noted above, the institution is to systematically identify, monitor, and manage any inmate who qualifies for "at risk" status. This must include observation by a QMHP, although the frequency of such observation is left to the QMHP's discretion.

III. CIRCUMSTANCES SURROUNDING THE INCIDENT

A. Mental Health Screening and Housing Assignments

After TW's transfer to Mecklenburg, Dr. G, the chief psychologist at Mecklenburg, performed a mandatory mental health screening to evaluate whether TW could be placed in a "special housing assignment", i.e. segregation, and if so, whether special instructions were needed (See Section IIC above). As TW had already been transferred to Mecklenburg, it was inevitable that he would be placed in segregation, although theoretically Dr. G, after the fact, could have recommended that TW not be placed in segregation. In any event, Dr. G concluded that TW could be placed in isolation, segregation, and detention with no special management instructions.

During the screening, TW indicated he had no current suicidal or self-injurious intent. Unlike previous mental health professionals who had evaluated TW, Dr. G gave no Axis I diagnosis. She listed his Axis II diagnoses as borderline personality, antisocial personality, and malingering. Depression, prominently featured in earlier evaluations, was not mentioned. As had occurred at Greensville, she assigned TW to the MH-2 classification.

Dr G's report does not indicate which of TW's records were reviewed as part of the mental health assessment. TW's records from Central State and from Powhatan and Greensville, including the letter from DG characterizing TW as malingering and manipulative, were included in his DOC records, and thus would presumably have been available to Dr G. However, other important records, including the psychological, psychiatric, and neuropsychological evaluations performed before and after TW's trial, were not in the DOC records. These records contained additional information that would have shed light on TW's depression and organic brain deficits. Nonetheless, Dr. G's evaluation of TW presented a milder picture of TW's mental health difficulties than appears even in the records to which she did have access. Her views bear

some similarity to those expressed in DG's letter, although Dr. G regarded TW as more immature and impulsive than consciously manipulative.

B. TW's Behavior and Mental Health Status while at Mecklenburg

TW was initially placed in Building 1, where he was on the caseload of Counselor GA. TW spent two weeks on isolation status in Building 1 due to the disciplinary offenses he had committed immediately before his transfer from Greensville. While in Building 1, TW received considerable verbal abuse from other inmates. The inmates also insulted TW's intelligence and his lack of control. He was verbally abusive to other inmates also, in terms that one counselor described as vulgar and at times racist. Not surprisingly, TW did not become friendly with other inmates.

Some officers reported that TW made enemies in part because he had no money, had received loans of items such as cigarettes from other inmates, and could not barter in return. Other inmates apparently began to threaten him, and he was transferred to Building 3 to escape the harassment. He did not get along well while there either, and was moved several times. His counselor in Building 3, Counselor GO, reported that inmates cursed TW and threw things at him as he was escorted to shower. According to this counselor, TW was upset over his lack of friends at the institution, and became isolated and lonely.

The corrections officers who worked in the segregation unit where TW was housed at Mecklenburg do not recall his behavior as difficult to manage in comparison to the other inmates. While TW had engaged in assaultive behavior at Greensville, at Mecklenburg he did not engage in such behavior. It should be noted that while there is less opportunity for assaultive behavior in segregation than there is in the general population, segregation inmates do have opportunities to engage in such behavior. This includes hurling urine and feces at officers and other inmates and attempting to assault officers who come in contact with them for various reasons; for example, escorting them to showers or recreation.

The most notable behavior in which TW engaged at Mecklenburg was self-mutilating behavior. At some point in the spring of 1997, TW went on a hunger strike, indicating that he wanted a kosher or Islamic diet. On May 8, 1997, he stated that he would remain on hunger strike until he either received the diet he wanted or died. On May 10, 1997, TW cut himself on the wrist "fairly deep" with a razor blade. He was placed in a stripped cell and on thirty-minute watches. He was apparently restrained in some manner in the stripped cell. He then reopened the wound, and was placed in four-point restraints and

checked every fifteen minutes. When Dr. G visited TW during this episode, she noted his history of "malingering."

On July 7, 1997, TW again cut himself on the arm. He was placed in a stripped cell and in restraints. Dr. G spoke to him while he was in the restraints, and indicated in her notes that he was calm and stated that he had no intention of self-harm. TW also told Dr. G that he was angry with the corrections officers, and that he would end up on death row. Dr. G recommended that he be removed from the restraints.

This was not TW's first mention of ending up on death row. On June 13, 1997, TW spoke with Dr. G and stated that he wanted a transfer to a different building or a different institution. Dr. G quotes him as stating that "if things don't change by Monday, whenever I get out of segregation, make arrangements on death row, life is suicidal." Dr. G did not interpret these statements as a suicide threat and did not recommend suicide watch, medication, or any other special precautions.

In her sessions with TW, Dr. G did not assess him as depressed or otherwise at risk. She does recall, however, that this was an individual with "few resources" - - i.e., his reading skills were very poor, he was highly immature and impulsive, and had limited intellectual resources. Accordingly, it was difficult for him to "do time." On one occasion, she noted his difficulty in coping with anger and frustration and his complaints of inmates harassing him.

Several of the officers who had regular contact with TW, including the counselors, made observations about TW's behavior that are pertinent to this investigation. Several of these individuals concluded that TW simply could not "grasp" the situation he was in, had difficulty in adjusting to segregation status, and had considerable trouble in "doing his time." As one counselor put it, TW would be fine for a day or two, but then "the walls close in." Counselor GO believes that TW was lonely and became progressively more withdrawn during his time at Mecklenburg.

Both of the counselors were aware of TW's mental health history, and made special efforts to get to know him and talk with him due to that history. Both counselors recall mentioning their concerns over TW's behavior and mental status to Dr. G on at least a couple of occasions. Dr. G does not recall this. However, she also stated that if the counselors did speak with her, this would not necessarily be documented. Counselors are not officially considered mental health staff and were not under Dr. G's supervision.

C. TW's Desire for a Transfer from Mecklenburg

Those who spoke regularly with TW recall that he often spoke of wanting a transfer from Mecklenburg. At times, he said he wanted a transfer specifically to Marion, where he would be treated in a mental health facility. At other times, he said he wanted to be anywhere but Mecklenburg. One corrections officer who got to know TW fairly well reported that he had threatened to "do something" in order to get a transfer, but was not specific. TW called the attorney from his criminal trial on a number of occasions, begging her to "get me out of here." This attorney believed that TW was upset and depressed and did not fully comprehend his situation.

There is some confusion over the possibility of TW's transfer to a mental health unit, either at Marion or another facility. Counselor GA believed that TW should have been housed in a mental health unit, and so informed Dr. G. He somehow had the impression that Dr. G agreed, and that TW was to be transferred, either to Marion or Brunswick, which also has a mental health unit. However, there is no indication in the records that Dr. G. ever recommended a mental health transfer for TW, and she states that she did not do so. This confusion may have made TW's situation more difficult, as he was apparently told by the counselor that he would in fact be transferred and he became upset and frustrated over the delays. Just a few days before TW's death, Counselor GA again told him he would be transferred. Counselor GO, who visited TW in Building #1 shortly before he hung himself, recalls TW telling him that he was going to be transferred. In fact, it appears that no transfer was in the works at all.

D. TW's Transfer to the Isolation Unit and his Suicide

On August 1, 1997, TW began to smear feces on himself and on the walls of his cell, and apparently also ate feces. He may have thrown feces from his cell. He was placed in four- point restraints, where he remained until he continued to smear and eat feces. Other inmates complained over the odor created by this behavior. Apparently because of those complaints, because TW showed no inclination to stop the behavior, and because the need to clean the cell was creating difficulty, TW was transferred from Building 3 to a block of 8 cells on the lower level in Building 1, referred to by several of the officers as an "isolation unit."

The significance of the behavior with the feces is unclear. One corrections officer, who had spoken with TW fairly frequently while he was in building 3, regarded it as part of an effort to get transferred to Marion. In fact, he recalls that immediately before he was transferred to the isolation unit, TW stated that

"this will get me transferred to Marion." Counselor GO believes that in his increasing loneliness and depression at Mecklenburg, he had decided to "go the mental health route" in an effort to improve his situation.

The cells to which TW was transferred were described by the warden as "the worst cells in Virginia." They differed from the segregation cells where TW had previously been housed in several significant respects. In Building 3, TW's cell had a small table, likely large enough to accommodate the eating tray, and a built-in stool. The isolation cells did not contain these amenities. The Building 3 cell had a single door with a small window looking out into the hallway. The isolation cell had an outer solid steel door and then an inner barred door separating the inmate from the steel door. The type of covering placed over the small window in the steel door, even if the inmate could look through it, which is doubtful, made it virtually impossible to see either in or out. The isolation cells are darker than the segregation cells, in part because they are on the lower level and in part because a sheet of material with small holes in it was placed over the window to the outside. According to the warden, these holes permitted enough light into the cell to satisfy state regulations. Technically, after the transfer to the isolation unit in Building 1, TW's status was still segregation, not isolation. However, simply by virtue of being in that unit he was subject to worse conditions than in his previous cell. If Mecklenburg in general housed "the worst of the worst," then this unit housed the very worst of all. Included in the group, for example, was one inmate who had killed another inmate and had attempted to kill a corrections officer. He and another inmate, who was an expert at making weapons and abusing guards, were considered such security risks that special precautions were employed to enter their cells and to escort them to the shower. It was in this group that TW found himself beginning on August 3, 1997.

TW's transfer was done as a matter of behavioral control and also administrative convenience, as the cells in the isolation unit are easier to hose down. Dr. G, as the prison psychologist, was not consulted about the move. He was apparently to remain in the isolation unit for a minimum of 90 days. TW did not repeat the behavior with the feces while in the isolation unit. He continued to be agitated over the possibility of a transfer; according to Counselor GA, who spoke with him daily, he was "pre-occupied with that." This counselor, under the mistaken belief that a transfer was imminent, attempted to reassure him. Counselor GA also visited him, and recalls the same withdrawn behavior that he had observed prior to the move to isolation. While Counselor GA understood the institution's concern over the feces problem, he was concerned that the move to isolation would worsen TW's condition.

On August 20, 1997, TW requested to meet with Dr. G. According to Dr. G's notes, he gave as a reason for his request to see her, his desire for a transfer to Powhatan Correctional Center. Also, according to those notes, TW stated during the visit that "he can't make it here." While this statement sounds ominous, Dr. G does not recall it as such, but only as part of his ongoing talk of a transfer. He also stated that "he can't do six months charge free." Dr. G indicates that this statement was made in response to her suggestion that he attempt to do six months charge-free, which would improve his situation at the institution. A few hours later, TW hung himself by a sheet from the bars of the inner-cell door. While access to the medical examiner's report and autopsy were not provided, the warden recalls that the time of suicide was estimated at 2:00 a.m. TW was not found until about 7:15 a.m. The corrections officer responsible for making hourly checks apparently did not perform those checks properly, and was fired as a result.

IV. FINDINGS AND CONCLUSION:

A. The Corrections Officers at Mecklenburg Neglected TW

The corrections officers at Mecklenburg neglected TW by failing to conduct proper hourly checks of his cell as dictated by DOC policy. The DOC agrees with this in the limited sense that the employee involved was disciplined.

However, the DOC apparently regards this neglect as a security lapse by a single employee. This is too narrow a view of the situation, because as discussed further below, the neglect also includes neglect of TW as a mentally ill individual at risk of suicide.

The investigation revealed a number of inadequacies in the DOC's treatment of TW. While these concerns likely do not rise to the level of deliberate indifference so as to create liability, they constitute violation of DOC policy as well as accepted principles pertaining to management of mentally ill inmates. The concerns over treatment of TW include:

1. Failure to appropriately monitor TW while in the isolation cell .
2. Inappropriate placement in an isolation area.
3. Failure to strictly comply with DOP 779, regarding identification of inmates "at-risk" in special housing.
4. Failure to conform to established national standards for monitoring mentally ill inmates and model suicide protocols.
5. Poor coordination between unit counselors and prison psychologist.
6. Understaffing of mental health services at Mecklenburg.

7. Disregard/discounting of suicide attempts and self-injurious behavior as "manipulative" and therefore not posing genuine threat to TW's safety.
8. Failure to perform a "psychological autopsy" after suicide.

All of these concerns are discussed below:

Failure to appropriately monitor TW while in the isolation cell, and inappropriate placement of the inmate in an isolation area. DOC policy requires hourly monitoring of inmates who are in segregation and isolation. In TW's case, this was either not done at all, or was not done properly. As noted above, the DOC has acknowledged this, and terminated the officer who was responsible for the hourly checks on that particular shift. As discussed further below, the lapse was particularly egregious given TW's emotional and behavioral history.

Just as important as the failure to check on TW appropriately is the institution's decision to place TW in isolation at all. TW was an inmate with a documented history of mental illness and of self-injurious behavior and suicide attempts. His most recent episode of self-mutilating behavior had taken place less than a month before he was placed in the isolation unit. While the psychologist, Dr. G, was either unaware of this or chose to discount it in her assessment, he had a history of depression. A counselor who was familiar with his behavior had expressed concern, apparently also ignored or discounted, over TW's increasingly withdrawn behavior. TW's repeated references to death row, his reference to life being "suicidal," and even his vague threats to "do something" to get out of Mecklenburg, when evaluated in the context of his history, should have raised concern as well. All of these factors were danger signals for placement of TW in segregation at all, much less in the "worst cells in Virginia."

There is no dispute in the literature that prior suicidal behavior is a risk factor for similar behavior in the future, and that isolation can have a negative effect on the mental health of any inmate, particularly those with pre-existing mental health problems. The risk is particularly great for inmates with a particular behavioral profile. "Whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration." (See Hayes, Prison Suicide: An Overview and Guide to Prevention, National Center on Institutions & Alternatives, funded by the Department of Justice, 1995).

Both Dr. G and the corrections officers noted TW's low tolerance for frustration and poor impulse control. This, combined with the history of depression and his poor adjustment to Mecklenburg, placed this inmate at

considerable risk in an isolation setting. Another factor to be considered is the behavior that resulted in TW's placement in the isolation unit. Smearing feces on the walls and eating feces appears, to the lay person, as behavior that indicates mental disturbance. However, there is no indication whatsoever in TW's records that this behavior was evaluated as a mental health matter or treated as such. As further evidence that TW's behavior was not considered in a mental health context, the prison psychologist was not consulted about TW's transfer to an isolation cell. (See Section E below for further discussion of the institutional response to manipulative behavior).

It is, of course, most difficult for even an experienced professional to predict when an individual will commit suicide, particularly when no overt suicidal ideation is expressed. In this case, Dr. G spoke with TW the afternoon before his death. She did not perceive his behavior as any different than it had been since he arrived at Mecklenburg, and because he had raised these subjects before, saw no reason for concern over his continued preoccupation with a transfer or his statement that he "could not make it here." Indeed, the counselor who visited him on the last day of his life, while aware that TW had been preoccupied and agitated, recalled that TW had been in relatively good control when he spoke with him that day. The other corrections officers who had dealings with TW that day had a similar impression, and were surprised to hear of the suicide, as was Dr G.

Accordingly, the institution's negligence with respect to TW was not the failure of the individuals who saw him on his last day of life to predict that he would be dead in a few hours. The negligence lies in its failure to view TW's behavior in the institution in a broader context, taking into account his past history. Had this been done, the risks of confining him in isolation would have been readily apparent.

B. Failure to Strictly Comply with DOP 779

Inmates such as TW often pose management problems for the institution in which they are confined. An obvious example of this was TW's behavior with the feces; regardless of the meaning of the behavior, it had to be stopped because it was intolerable for both corrections staff and the other inmates.

Inmates who engage in behavior that is difficult to manage often end up, as TW did, in segregation assignments. The DOC has recognized the need for special precautions in managing the behavior of mentally disturbed inmates through housing assignments, and in response to that need, has promulgated DOP #779. As that policy states - Inmates who are identified as "at risk" as a result of emotional and/or behavioral problems can be difficult to manage in an

institutional setting. Detention of such individuals in close confinement may increase the risk of deterioration, of self-harm, and/or of being a danger to others. It is the policy of the Division of Administration that inmates considered "at risk" are identified, monitored, and managed for mental health services needs by a Qualified Mental Health Professional while in a special Housing Unit to help reduce the risk of deterioration, self harm, or harm to others. The identification, monitoring, and management of inmates considered "at risk" in such units shall be part of the Institution's mental health service program.

While the principles set forth in DOP #779 are sound, the policy gives the qualified mental health professional who assesses the inmate very broad discretion in its implementation. The only specific mandate is a weekly physical assessment by a nurse. Even so, there is substantial basis to conclude that the policy was violated with respect to TW. This is so because the monitoring and management called for by the policy were virtually absent in any form. Although TW met four out of five of the "at risk" criteria, any one of which would have been sufficient to place him in the at-risk category, he was authorized for placement in a segregation assignment with no special requirements whatsoever. Even assuming that a short stay in isolation was necessary to curb the intolerable behavior preceding the move, no stepped-up observation or counseling of the inmate was recommended. Medication management was not considered. Thus, while the policy does not mandate any particular form of monitoring and management of at-risk inmates, if the policy means anything at all, it was violated in this case. At a minimum, the policy itself should be amended to provide more specific requirements; see Section C and Part V, below.

C. Failure to Conform to Established National Standards for Monitoring Mentally Ill Inmates and Model Suicide Precaution Protocols

The National Commission on Correctional Health Care (NCCHC) has established standards for suicide prevention and precaution that are more comprehensive than Virginia DOC policy as embodied in DOP #773, discussed above in Section A, and DOP #780, Management of Self-injurious and Suicidal Inmates (see discussion at p. 5, above). TW's management at Mecklenburg did not conform to these standards.

First, these standards require that the institution maintain a suicide prevention plan that "should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal." (See Prison Suicide: An Overview and Guide to Prevention, p. 13.) As discussed above in the context of housing assignments, the institution had established no plan to monitor

TW's condition, nor was there any general plan that specified the type of monitoring required for inmates at risk of suicide, including those placed in isolation. Second, the NCCHC has promulgated a model suicide precaution protocol that goes beyond the requirements of DOP #780. DOP #780 establishes fifteen-minute and constant watch procedures for inmates who are actively suicidal. These procedures are acceptable as far as they go, but do not provide precautions for inmates at moderate risk of suicide or who are at risk for becoming severely depressed/suicidal. These inmates, described as Level 3 and Level 4 inmates in the NCCHC protocol, would receive special precautions under that protocol. A Level 4 inmate, considered at risk based on past history but who has not attempted suicide recently or expressed suicidal ideation, would be checked visually every half hour while both awake and asleep. Corrections officers would be specifically instructed to observe the inmate for symptoms of depression and signs of suicidal ideation, and to notify health staff when new signs or symptoms occur. All staff would have "good observational skills and knowledge of signs and symptoms to look for." (See NCCHC Sample Suicide Precaution Protocol, attached). These standards were not employed in TW's case. If they had been, his chances of surviving would have been considerably greater.

D. Poor Coordination Between Unit Counselors and Prison Psychologist; Understaffing of Mental Health Services at Mecklenburg

As the above discussion indicates, DOC had not adopted suicide precaution standards that would have required a higher level of monitoring for an inmate such as TW. Even without such standards, however, TW would have been better protected had there been better coordination among staff. Indeed, poor communication among staff has been identified as an operational factor that contributes to prison suicides. (See Prison Suicide: An Overview and Guide to Prevention, p. 3.)

In TW's case, the unit counselors should have been a crucial link between TW and other staff, in particular the prison psychologist. These individuals were familiar with TW's history, and made special efforts to stay in contact with him due to his mental health history, problems with other inmates, and difficulty adjusting to segregation. Both were concerned over his condition; one of them recommended that he be housed in a mental health unit, and the other expressed concern to Dr. G over his increasingly withdrawn behavior. However, there is no formal mechanism for communication between the counselors and the psychologist, and communications and recommendations are generally not recorded by the psychologist. And, possibly because their roles within the institution are so different and because they are in different chains of command, the psychologist did not appear to view the counselors'

contributions as noteworthy. Although it is impossible to know for certain whether this lack of communication made a difference for TW, it was certainly a risk factor.

It is impossible to assess the adequacy of the mental health training provided to the staff in the segregation units because information about the mental health training they receive, and who had received it at the time TW was confined at Mecklenburg, was not provided to the investigator. However, it is apparent that at a minimum, information about the mental health status of inmates and how to manage them was not provided to corrections officers in a consistent manner.

The psychologist was hampered in her ability to assess and counsel inmates by the understaffing for mental health services at Mecklenburg. Not surprisingly, inadequate psychological services during incarceration has been identified as a contributing factor in prison suicides. (See Prison Suicide: An Overview and Guide to Prevention, p. 3.) At Mecklenburg, there was supposed to be a second psychologist during this time period, and indeed for some years, but none was provided. This lack of help no doubt hampered Dr. G's ability to perform thorough review of inmates' records, assess changes in inmates' emotional state, and provide services to inmates in need of counseling and/or medication. Given these shortcomings, the lack of coordination among available staff was particularly unfortunate.

E. Disregard/Discounting of Suicide Attempts and Self-injurious Behavior as "Manipulative" and, Therefore, not Posing a Genuine Threat to TW's Safety

The DOC's view of TW as primarily manipulative rather than mentally ill permeates his corrections records and strongly influenced the institutions' responses to his behavior. It influenced the way in which his self-injurious behavior was perceived and reacted to, and therefore contributed to his death. This is unfortunate, because studies show that "manipulative" inmates who engage in self-injurious behavior pose a genuine risk of suicide and should be managed as such.

Both DG, the QMHP at Greensville, and Dr. G at Mecklenburg, regarded TW as manipulative and a malingerer. At Greensville, TW had an Axis I diagnosis of depression, and even DG mentioned that TW suffered from depression. However, Dr. G dropped this diagnosis entirely from his profile and diagnosed him only as suffering from an anti-social and a borderline personality. These conditions do not constitute major thought or mood disorders, and are regarded, in DG's words, as primarily behavioral issues rather than a "remarkable mental illness." These diagnoses go hand-in-hand with the

manipulative label. Moreover, because Dr. G regards these personality disorders as impervious to improvement through medication and did not believe TW was depressed, there was little chance that she would recommend medication for TW in order to improve his mental state. The DOC's view of TW as manipulative apparently contributed to his mental health classification. He was placed in the MH-2 category, generally reserved for inmates with mild mental illness who are relatively stable and can function in the general population, rather than MH-3, used for inmates with a documented Axis I diagnosis who are unstable, require treatment, and typically cannot function in the general population for extended periods. As an MH-3, which his prior diagnosis and history suggest was the appropriate classification, TW's behavior would more likely have been viewed from a mental health perspective rather than purely from a behavioral management perspective.

Moreover, there is substantial evidence that TW was not regarded at Mecklenburg as being of substantial risk of suicide. He was placed in segregation with no special precautions or conditions. His placement in the isolation unit is clear evidence that he was not regarded as a suicide risk—the warden himself stated that "we would not put a suicidal inmate here." While this is no doubt true of an inmate who was actively expressing suicidal intent, the institution did not hesitate to place TW there, despite his history of suicide attempts and self-injurious behavior, including two cutting incidents at Mecklenburg, one less than a month before he was moved to isolation.

Self-injurious behavior of the sort TW engaged in is often regarded by both corrections staff and mental health professionals as primarily manipulative, i.e. as a way to get a trip to the infirmary, a different housing assignment, more attention from staff, and so on, rather than a danger sign of more serious behavior to come. This view of such behavior was expressed by a number of the corrections staff interviewed. DG told the investigator that TW was never "truly suicidal," and used self-injurious suicidal behavior to "get what he wanted." Dr. G regards such behavior as primarily the result of anger and frustration. Her notes on TW, however, indicate that she perceived his cutting behavior as part of his history of "malingering." Counselor GO recognized the manipulative component to this behavior, but also regarded it as a danger sign; a view that was apparently not shared by those who were in the best position to protect TW from his self-destructive tendencies.

TW's final self-injurious, "crazy" behavior was the consumption of his own feces, discussed above in Section A. To the corrections staff and apparently also the psychologist, this was interpreted as a continuation of TW's efforts at manipulation, and as such would only cease through further deprivation and discipline. This view prevented the staff from evaluating this behavior, even

with its manipulative component, as a cry for help rather than merely a management problem.

Research does not support the view that as a manipulator, TW was not a serious suicide risk. One study of prison suicide showed that 59 percent of those who committed suicide in the prisons studied had engaged in "manipulative attention-seeking behavior" or "presented problems of control." Both lethal, near-lethal, and non-lethal attempts are most often made on impulse, and the primary motivating factors—hopelessness, depression, and inward-directed rage—are the same for this range of acts. And, "manipulative" inmates who engage in suicidal gestures often downplay their significance after the fact, as TW did to Dr. G. (See Haycock, Manipulation and Suicide Attempts in Jails and Prisons, Psychiatric Quarterly, reprinted in Jail Suicide Update, Winter 1992.) While mental health professionals disagree over whether the response to "truly suicidal" and "manipulative" inmates should differ, and whether this distinction is useful at all, there is broad agreement that isolation is not the way to deal with such behavior. "Manipulative" inmates are at substantial risk of escalating their behavior and dying, even if by accident and/or miscalculation of the staff's responsiveness. (See Prison Suicide: An Overview and Guide to Prevention, p. 6.) For an inmate who had a history of depression, suicide attempts, and gestures, who had limited mental capacity, who had adjusted very poorly to Mecklenburg in general and to segregation, who had become withdrawn, who was desperate for a transfer that never seemed to be (and in fact was not) forthcoming—placement in isolation was a recipe for disaster, and disaster was not long in coming. At a minimum, a stepped-up level of checks should have been ordered, but was not. The staff in isolation should have been informed that this inmate was at risk, but they were not.

F. Failure to Perform a "Psychological Autopsy" after the Suicide

After the suicide, of course, it was too late to help TW. However, a thorough medical and administrative review should be performed in order to assist other inmates in the future. The review should include:

1. a critical review of the circumstances surrounding the incident;
2. a critical review of prison procedures relevant to the incident;
3. a synopsis of all relevant training received by involved staff;
4. a review of pertinent medical and mental health services involving the victim;
5. any recommendations for changes in policy, training, physical plant, medical, mental health, and operational procedures. (See Prison Suicide: An Overview and Guide to Prevention, p. 25.) While the investigator was not given access to the institution's internal

investigation of the suicide, the warden indicated that it did not meet these standards.

V. RECOMMENDATIONS:

The conditions that led to the incident under investigation are thoroughly discussed above. It should be noted that conditions at Mecklenburg are considerably different than they were when TW was confined there because Mecklenburg has been transformed into an intake and processing center for inmates. "The worst of the worst" are at Red Onion and other institutions. Nevertheless, it is reasonable to conclude that other institutions could benefit from the following recommendations:

1. Full compliance with DOP 779 and revision of that policy to include the following:

   a) Development of a treatment and monitoring plan for all inmates identified as "at risk" under DOP 779 criteria;
   b) A plan that would include increased monitoring (i.e. at least every thirty minutes) of all at-risk inmates placed in segregation assignments and regular reassessment of their condition in that assignment by a QMHP; and
   c) Adoption, either in DOP 779 or elsewhere, of the NCCHC model suicide precaution protocol (attached).

2. Adoption of the NCCHC Standard P-58 for Suicide Prevention, of which the protocol in section 6 above forms a part (attached).

3. Recognition that unit counselors have valuable information to offer to the mental health staff, particularly where the mental health staff is limited to one or two psychologists who have difficulty in monitoring the condition of all mentally ill inmates, and formulating a system of regular contact and/or case reviews between counselors and mental health staff.

4. Training for corrections officers and QMHP's on the serious risk of further self-harm to "manipulative" inmates with a history of self-injurious behavior and/or suicide attempts.

5. Appropriate and consistent briefing concerning these inmates and their mental health history to the corrections staff who will come into contact with them.

6. Conducting post-suicide reviews that conform to NCCHC standards (attached) Last modified: February 15, 2002.